

Early and Periodic Screening Diagnosis and Treatment TRACKING FORM 9 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name		First Name		AHCCCS ID		D.O.B.		AGE	
Primary Care Provider				Date of Examination		Health Plan Name			
Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile			

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL

Comments

T _____

P _____

R _____

NUTRITIONAL ASSESSMENT ☐ Breast Feeding ☐ Formula (type) _____ ☐ Whole Milk
Supplements: ☐ Fluoride ☐ Vitamins ☐ Iron ☐ Solids

SENSORY ASSESSMENT Vision: Within normal limits? ☐ Yes ☐ No, Refer
Hearing/Speech: Within normal limits? ☐ Yes ☐ No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? ☐ Yes ☐ No

Responds to own name, understands a few words, "no-no" "bye-bye", may say "mama" or "dada" nonspecifically, crawls, sits independently, may pull to stand (If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

Yes No

Skin		
Head		
Eyes		
ENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Hgb./Hct. <small>(Ordered if not done previously)</small>		
	High	Low
Lead Screen: Verbal Risk		
	Yes	No
Lab Lead Screen		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed?

☐ Yes ☐ No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today?

☐ Yes ☐ No

Is there a current immunization record in the medical chart?

☐ Yes ☐ No

ANTICIPATORY GUIDANCE

- ☐ Injury prevention
- ☐ Good parenting practices
- ☐ Baby-proof home, pool
- ☐ Nutrition

- ☐ Talk to child
- ☐ Self-feeding
- ☐ Sleep practices

REFERRALS

- ☐ CRS
- ☐ WIC
- ☐ Specialty _____
- ☐ Other

Next scheduled visit

Clinician Name

Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)?

☐ Yes

☐ No